2024 Benefits Enrollment and Change Form

Faculty & Staff

Effective the 1st of : _______________2024 Terminating the last day of __________2024

Employee Information:

Name (Please Print)	Social Security Number	Banner ID Number
Date of Birth	Hire Date	☐ 9-month ☐ 12-month Pay Schedule

Contact Information:

Street	City	ST	Zip

Home Phone

Work Phone

Plan Elections:

Health ☐ Plan A ☐ Plan B ☐ HSA * ☐ Decline ☐ Employee Only ☐ Employee & Spouse ☐ Family ☐ Employee & Child(ren)	**Dental** ☐ Plan A ☐ Plan B ☐ Decline ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family
Vision ☐ Accept ☐ Decline ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family	**Basic Life/AD&D/LTD** ☒ 1x annual salary ☒ Accidental Death & Dismemberment ☒ Long-Term Disability
Additional Life ☐ Decline ☐ 1x annual salary ☐ 2x annual salary ☐ 3x annual salary (requires evidence of insurability)	**Dependent Life** ☐ Decline ☐ $5,000 ☐ $10,000 ☐ $15,000 (requires evidence of insurability)
Short Term Disability ☐ Accept ☐ Decline ☐ 14-day waiting period ☐ 29-day waiting period	**Accident Insurance** ☐ Accept ☐ Decline ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family
* Health Savings Account: *Employer provided* - ☐ $1,000 per employee; ☐ $2,000 per family per year.	

Dependent Information:

Name	SSN	Spouse (S)/ Child (C)	Gender	DOB	Plan(s)	Add/Drop
		☐ S ☐ C	☐ M ☐ F		☐ Med ☐ Den ☐ Vsn ☐ Acc	☐ Add ☐ Drop
		☐ S ☐ C	☐ M ☐ F		☐ Med ☐ Den ☐ Vsn ☐ Acc	☐ Add ☐ Drop
		☐ S ☐ C	☐ M ☐ F		☐ Med ☐ Den ☐ Vsn ☐ Acc	☐ Add ☐ Drop
		☐ S ☐ C	☐ M ☐ F		☐ Med ☐ Den ☐ Vsn ☐ Acc	☐ Add ☐ Drop
		☐ S ☐ C	☐ M ☐ F		☐ Med ☐ Den ☐ Vsn ☐ Acc	☐ Add ☐ Drop

If any of your dependents live in a different zip code, please contact the Human Resources Office for network availability.

Reason:

- ☐ New Employee
- ☐ Retirement
- ☐ Change
  - ☐ Address
  - ☐ Name
- ☐ Add Dependent
  - ☐ Newborn
  - ☐ Special Enrollee (Child or Spouse)
  - ☐ Spouse Loss of Coverage
- ☐ Drop Dependent
  - ☐ Divorce/Legal Separation
  - ☐ Death
  - ☐ Enrollment in Other Insurance
  - ☐ Dependent Loss of Eligibility
- ☐ Termination
- ☐ Change Life Insurance Beneficiary
- ☐ Medicare Eligible

☐ Other _____

Life and AD&D Insurance Primary Beneficiary:

Name	Relationship	Address	Percentage	Phone

Life and AD&D Insurance Contingent Beneficiary:

Name	Relationship	Address	Percentage	Phone

Other Coverage:

Are you or any of your covered dependents currently covered by other insurance plans, including Medicare or Medicaid? If yes, please provide the plan information below or attach an additional sheet with the plan information.

Name of Insured	**Insured's SSN**	**Name of Carrier**	**Address of Carrier**

For New Employees Only:

Truman State University will automatically set up your payroll deductions so that your premiums (medical, dental and vision) will be deducted from your monthly check pre-tax. Please check this box if you wish to have these premiums deducted post-tax: ☐

For Existing Employees:

Truman State University has set up your payroll deductions so that your premiums (medical, dental and vision) will be deducted from your monthly check pre-tax, unless you have opted out of that benefit. If you wish to have your premiums taken out post-tax, you are able to make that change during the annual Missouri Cafeteria Plan Open Enrollment Period October 1 to December 1. (This is a separate process than Truman's Open Enrollment Period). After making the change with MoCafe, you must also notify Human Resources of the change. For more information, visit mocafe.com.

I certify that, to the best of my knowledge, that the information provided on this form is correct and complete. I authorize Truman State University to deduct contributions for the requested coverage from my payroll. I understand that it is my responsibility to notify Truman State University within thirty-one (31) days of a change in family status and that premiums paid for ineligible dependents do not constitute coverage. I understand that benefits are subject to limitations as presented in the plan document for each line of coverage and that should I wish to add dependents at a later date, some restrictions may apply.

_____ _____

Signature Date